Washington State Health Care Authority

Washington Apple Health (Medicaid)

Neurodevelopmental Centers Billing Guide

January 1, 2025

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict arises between this document and a governing statute or a Health Care Authority (HCA) rule arises, the governing statute or HCA rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If the broken link is in the most recent guide, please notify us at askmedicaid@hca.wa.gov.

About this guide*

This publication takes effect **January 1, 2025,** and supersedes earlier billing guides to this program. Unless otherwise specified, the program in this billing guide is governed by WAC 182-545-900.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

> Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by HCA.

Refer also to HCA's ProviderOne billing and resource guide for valuable information to help you conduct business with HCA.

Services and equipment related to the programs listed below are not covered by this guide and must be billed using their specific provider guide:

- Hearing Services
- Home Health Services
- Outpatient Hospital Services
- Outpatient Rehabilitation
- Physician-Related Services/Health Care Professional Services

* This publication is a billing instruction.

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How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's provider alerts webpage.

To access provider documents, go to HCA's provider billing guides and fee schedules webpage.

Confidentiality toolkit for providers

The Washington State Confidentiality Toolkit for Providers is a resource for providers required to comply with health care privacy laws.

Where can I download HCA forms?

To download an HCA form, see HCA's Forms & Publications webpage. Type only the form number into the Search box (Example: 13-835).

Copyright disclosure

What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Coverage Table – Pediatric Evaluations	Added HCPCS code G0136 to the pediatric evaluation coverage table and added a related note box referring to HCA's Physician-Related Services/Health Care Professional Services Billing Guide for more information	Policy change. Beginning January 1, 2025, HCA pays for a social determinants of health risk screening during specific qualifying visits. (This change arises from section 211(103)(b), chapter 376, Laws of 2024 (ESSB 5950).)

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Available Resources

Topic	Resource
Becoming a provider or submitting a change of address or ownership	See HCA's ProviderOne Resources webpage
Finding out about payments, denials, claims processing, or Health Care Authority managed care organizations	See HCA's ProviderOne Resources webpage
Electronic billing	See HCA's ProviderOne Resources webpage
Private insurance or third-party liability, other than Health Care Authority managed care	See HCA's ProviderOne Resources webpage
Obtaining prior authorization	See HCA's ProviderOne Resources webpage
Definitions	Refer to chapter 182-500 WAC for a complete list of definitions for Washington Apple Health
Provider billing guides, fee schedules, and other Health Care Authority documents	See HCA's online Rates Development Fee Schedules

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About the Program

What do neurodevelopmental centers do?

Neurodevelopmental centers (NDCs) provide outpatient physical therapy, speech therapy, occupational therapy, and audiology services to children with neuromuscular or developmental disorders, such as cerebral palsy, Down syndrome, autism, and pervasive developmental delay. NDCs serve clients age 20 and younger, although some NDCs further limit the age range they serve.

Who may provide services?

After a client's primary care physician initiates NDC services by requesting an evaluation, the following health care professionals may provide services within their scope of practice to eligible clients in neurodevelopmental centers:

- Licensed occupational therapists
- Licensed occupational therapy assistants (OTA) supervised by a licensed occupational therapist
- Physiatrists
- Licensed physical therapists
- Licensed physical therapist assistants supervised by a licensed physical therapist
- Speech-language pathologists who have been granted a certificate of clinical competence by the American Speech, Hearing and Language Association
- Speech-language pathologists who have completed the equivalent educational and work experience necessary for such a certificate
- Audiologists who are licensed or registered to perform audiology services.

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Client Eligibility

Most Apple Health clients are enrolled in an HCA-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See HCA's Apple Health managed care page for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Clients age 20 and younger may be eligible to receive services in a neurodevelopmental center, depending on their benefit package. Check the client's services card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service HCA will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Apple Health**. For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in HCA's ProviderOne Billing and Resource Guide.

If the patient is eligible for Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the orange note box below.

Step 2. **Verify service coverage under the Apple Health client's benefit package**. To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see HCA's Program Benefit Packages and Scope of Services webpage.

Note: Patients who are not Apple Health clients may apply for health care coverage in one of the following ways:

- **Online**: Go to **Washington Healthplanfinder** - select the "Apply Now" button. For patients age 65 and older or on Medicare, go to **Washington Connections** select the "Apply Now" button.
- **Mobile app:** Download the **WAPlanfinder app** – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 1-855-627-9604 (TTY).
- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form.
  To download an HCA form, see HCA's Free or Low Cost Health Care, **Forms & Publications** webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older or on Medicare, complete the *Washington Apple Health Application for Aged, Blind, Disabled/Long-Term Services and Support (HCA 18-005)* form.

Are clients enrolled in an HCA-contracted managed care organization (MCO) eligible?

Yes. Most Apple Health clients are enrolled in one of HCA's contracted managed care organizations (MCO). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an HCA-contracted MCO must be obtained by the client through the MCO's contracted network. The MCO is responsible for:

- Payment of covered services
- Payment of services referred by a provider participating with the plan to an outside provider

Note: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in **WAC 182-502-0160**.

Managed care enrollment

Most Apple Health clients are enrolled in an HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Apple Health eligibility determination. **Exception:** Apple Health Expansion clients are enrolled in managed care and will not start their first month of eligibility in the FFS program. For more information, visit Apple Health Expansion. Providers must check eligibility to determine enrollment for the month of service.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care. Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Checking eligibility

Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to HCA's Apply for or renew coverage webpage.

Clients' options to change plans

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**:

  Go to Washington Healthplanfinder website.

- **Available to all Apple Health clients:**
  - Visit the ProviderOne Client Portal website:
  - Request a change online at ProviderOne Contact Us (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

For online information, direct clients to HCA's Apple Health Managed Care webpage.

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Apple Health clients do not meet the qualifications for managed care enrollment. These clients are eligible for physical health services under the fee-for-service (FFS) program.

In this situation, each managed care organization (MCO) will have a Behavioral Health Services Only (BHSO) benefit available for Apple Health clients who are not in integrated managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an integrated HCA-contracted managed care plan are automatically enrolled in a BHSO except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the FFS program will reimburse providers for the covered services. Examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption Support and Foster Care Alumni.

Integrated managed care

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care's (CC) Apple Health Core Connections Foster Care program receive both medical and behavioral health services from CC.

Clients under this program are:

- Under the age of 18 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

These clients are identified in ProviderOne as "**Coordinated Care Healthy Options Foster Care**."

The Apple Health Customer Services team can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care and Adoption Support (FCAS) team at 1-800-562-3022, Ext. 15480.

Apple Health Expansion

Individuals age 19 and older who do not meet the citizenship or immigration requirements to receive benefits under federally funded programs and who receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contract health plan. For more information, visit **Apple Health Expansion**.

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see HCA's **Mental Health Services Billing Guide**, under *How do providers identify the correct payer*?

American Indian/Alaska Native (AI/AN) Clients

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's (HCA) **American Indian/Alaska Native webpage**.

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Coverage

What services are covered?

The Health Care Authority (HCA) covers unlimited services in a neurodevelopmental center for eligible clients age 20 and younger with the exception of clients age 19 through 20 receiving **Medical Care Services** (MCS). MCS clients age 19 through 20 have a limited outpatient rehabilitation benefit. See the outpatient benefit limit tables for **occupational therapy**, **physical therapy**, and **speech therapy** for MCS clients

Clients enrolled in a Health Care Authority -contracted managed care plan who are referred for outpatient rehabilitation services (Physical Therapy, Occupational Therapy and Speech Therapy) by their primary care provider are eligible to receive those services in a neurodevelopmental center (NDC).

Telemedicine

Refer to HCA's **Provider billing guides and fee schedules webpage**, under Telehealth, for more information on the following:

- Telemedicine policy, billing, and documentation requirements, under *Telemedicine policy and billing*
- Audio-only procedure code lists, under *Audio-only telemedicine*

For COVID PHE telemedicine/telehealth policies, refer to HCA's **Provider Billing Guides and Fee Schedules webpage**, under *Telehealth* and *Clinical policy and billing for COVID-19*.

Effective for dates of service on and after October 1, 2023

Audio-visual telemedicine

HCA pays for evaluation, re-evaluation, and treatment of some physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services when provided via audio-visual telemedicine.

HCA pays for telehealth services for PT, OT, or ST when provided via audio-visual telemedicine and billed with specific procedure codes if clinically appropriate as determined by the practitioner, per standard of care.

Services delivered by synchronous audio-visual technology may require participation of a caregiver to assist with the treatment. Providers are responsible for making this determination and ensuring there is appropriate assistance or supervision, or both.

Providers may bill for services provided via audio-visual telemedicine using the following procedure codes:

- **Physical therapy evaluations—low, moderate, and high complexity and re-evaluation**

CPT® code	Short description
97161	Pt eval low complex 20 min
97162	Pt eval mod complex 30 min
97163	Pt eval high complex 45 min
97164	Pt re-eval est plan care

Note: If, during the telemedicine evaluation, it is determined that a satisfactory and valid examination cannot be performed, arrange for an in-person assessment. Do not begin treatment until an acceptable evaluation has been performed and a treatment plan has been developed.

- **Occupational therapy evaluation—low, moderate, and high complexity and re-evaluation**

CPT® code	Short description
97165	Ot eval low complex 30 min
97166	Ot eval mod complex 45 min
97167	Ot eval high complex 60 min
97168	Ot re-eval est plan care

Note: If, during the telemedicine evaluation, it is determined that a satisfactory and valid examination cannot be performed, arrange for an in-person assessment. Do not begin treatment until an acceptable evaluation has been performed and a treatment plan has been developed.

- **Physical therapy or occupational therapy services (individual or group)**

CPT® code	Short description
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97116	Gait training therapy
97150	Group therapeutic procedures
97530	Therapeutic activities
97535	Self care mngment training
97750	Physical performance test

- **Speech evaluation and re-evaluation**

Procedure code	Short description
CPT® 92521	Evaluation of speech fluency
CPT® 92522	Evaluate speech production
CPT® 92523	Speech sound lang comprehen
CPT® 92524	Behavral qualit analys voice
CPT® 92610	Evaluate swallowing function
HCPCS S9152	Speech therapy, re-eval

Note: If, during the telemedicine evaluation, it is determined that a satisfactory and valid examination cannot be performed, arrange for an in-person assessment. Do not begin treatment until an acceptable evaluation has been performed and a treatment plan has been developed.

- **Speech therapy (individual or group) services**

CPT® code	Short description
92507	Speech/hearing therapy
92508	Speech/hearing therapy
92521	Evaluation of speech fluency
92522	Evaluate speech production
92523	Speech sound lang comprehen
92526	Oral function therapy

- **Caregiver training services**

CPT® code	Short description
97550	Caregiver training 1st 30 min
97551	Caregiver training ea addl 15
97552	Group caregiver training

Audio-only telemedicine

(CPT® codes 92507, 92521, 92522, and 92523)

Audio-only telemedicine may require participation of a caregiver to assist with the treatment. Providers are responsible for making this determination and ensuring appropriate assistance or supervision, or both.

Audio-only telemedicine for the evaluation of speech is:

- Allowed for patients who have already had a face-to-face (in-person), initial evaluation with the provider.
- Permitted for less than 50% of the visits per year.
- Not allowed for outpatient physical or occupational therapy.

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Coverage Table

Note: Due to its licensing agreement with the American Medical Association, the Health Care Authority publishes only the official, short CPT® code descriptions. To view the full descriptions, refer to a current CPT® book.

Neurodevelopmental centers must use the appropriate modifier when billing the Health Care Authority:

Modality	Modifiers
Physical Therapy	GP
Physical Therapy Assistant	CQ
Occupational Therapy	GO
Occupational Therapy Assistant	CO
Speech Therapy	GN
Audiology and Specialty Physician	AF

Physical Therapy

CPT ® Code	Modifier	Short Description	Comments
64550		Apply neurostimulator	Not covered
95851	GP	Range of motion measurements	Excluding hands
95852	GP	Range of motion measurements	Including hands
95992	GP	Canalith repositioning proc	
96125	GP	Cognitive test by hc pro	
97010	GP	Hot or cold packs therapy	Included in primary services. Bundled
97012	GP	Mechanical traction therapy	
97014	GP	Electric stimulation therapy	
97016	GP	Vasopneumatic device therapy	
97018	GP	Paraffin bath therapy	
97022	GP	Whirlpool therapy	
97024	GP	Diathermy treatment	
97026	GP	Infrared therapy	
97028	GP	Ultraviolet therapy	

Note: The following procedure codes require the therapy provider to be in constant attendance.

CPT® Code	Modifier	Short Description	Comments
97161	GP	PT eval low complex 20 min	
97162	GP	PT eval mod complex 30 min	
97163	GP	PT eval high complex 45 min	
97164	GP	PT re-eval est plan care	
97005		Athletic train evaluation	Not covered
97006		Athletic train re-evaluation	Not covered
97032	GP	Electrical stimulation	Timed 15 min units
97033	GP	Electric current therapy	Timed 15 min units
97034	GP	Contrast bath therapy	Timed 15 min units
97035	GP	Ultrasound therapy	Timed 15 min units
97036	GP	Hydrotherapy	Timed 15 min units
97039	GP	Physical therapy treatment	
97110	GP	Therapeutic exercises	Timed 15 min units
97112	GP	Neuromuscular reeducation	Timed 15 min units
97113	GP	Aquatic therapy/exercises	Times 15 min units
97116	GP	Gait training therapy	Timed 15 min units
97124	GP	Massage therapy	Timed 15 min units
97139	GP	Physical medicine procedure	
97140	GP	Manual therapy	Timed 15 min units
97150	GP	Group therapeutic procedures	

CPT® Code	Modifier	Short Description	Comments
97530	GP	Therapeutic activities	Timed 15 min units
97533		Sensory integration	Not covered
97535	GP	Self-care management training	Timed 15 min units
97542	GP	Wheelchair management training	Assessment is limited to four 15-min units per assessment. Indicate on claim wheelchair assessment
97545		Work hardening	Not covered
97546		Work hardening add-on	Not covered
97550		Caregiver training 1st 30 min	Code status: By Report (BR)
97551		Caregiver training ea addl 15	Code status: By Report (BR)
97552		Group caregiver training	Code status: By Report (BR)
97597	GP	Active wound care/20 cm or <	Do not use in combination with 11040-11044. Limit one per client per day.
97598	GP	Active wound care > 20 cm	Do not use in combination with 11040-11044
97602	GP	Wound(s) care non-selective	Do not use in combination with 11040-11044
97605	GP	Neg press wound tx, <50 cm	Included in primary services. Bundled
97606	GP	Neg press wound tx, >50 cm	Included in primary services. Bundled
97750	GP	Physical performance test	Do not use to bill for an evaluation

CPT® Code	Modifier	Short Description	Comments
97755	GP	Assistive technology assess	Timed 15 min units
97760	GP	Orthotic mgmt and training	Can be billed alone or with other PT/OT procedure codes
97761	GP	Prosthetic training	Timed 15 min units
97763	GP	Orthc/prostc mgmt sbsq enc	
97799	GP	Physical medicine procedure	Use this code for custom hand splints. Use modifier to indicate right (RT) or left (LT) hand. Documentation must be attached to claim.

Pediatric Evaluations

CPT® Code	Modifier	Short Description	Comments
99202		Office/outpatient visit, new	
99203		Office/outpatient visit, new	
99204		Office/outpatient visit, new	
99205		Office/outpatient visit, new	
99211		Office/outpatient visit, est	
99212		Office/outpatient visit, est	
99213		Office/outpatient visit, est	
99214		Office/outpatient visit, est	
99215		Office/outpatient visit, est	
G0136*		Adm of soc dtr assess 5-15 m	

***Note**: HCA considers a social determinants of health risk screening (HCPCS code G0136) medically necessary for specific qualifying visits. See HCA's Physician-Related Services/Health Care Professional Services Billing Guide for the complete policy and a list of qualified visits.

Speech-language pathologists

CPT® Code	Modifier	Short Description	Comments
92521	GN	Evaluation of speech fluency	
92522	GN	Evaluate speech production	
92523	GN	Speech sound lang comprehen	
92524	GN	Behavral qualit analys voice	
92507	GN	Speech/hearing therapy	
92508	GN	Speech/hearing therapy	
92526	GN	Oral function therapy	
92551	GN	Pure tone hearing test, air	
92597	GN	Oral speech device eval	
92605	GN	Evaluation for rx of nonspeech device 1 hr	Limit 1 hour Included in primary services. Bundled
92618	GN	Eval for rx of nonspeech device addl	Add on to 92605 Each additional 30 minutes. Bundled
92606	GN	Non-speech device service	Included in Primary services. Bundled
92607	GN	Ex for speech device rx, 1hr	Limit 1 hour
92608	GN	Ex for speech device rx addl	Each additional 30 min
92609	GN	Use of speech device service	
92610	GN	Evaluate swallowing function	
92611	GN	Motion fluoroscopy/swallow	
92630	GN	Aud rehab pre-ling hear loss	
92633	GN	Aud rehab postling hear loss	

CPT® Code	Modifier	Short Description	Comments
96112	GN	Devel tst phys/qhp 1st hr	Covered under the physician fee schedule for qualified providers.
96113	GN	Devel tst phys/qhp ea addl	Covered under the physician fee schedule for qualified providers.
96125	GN	Cognitive test by hc pro	
97129	GN	Ther ivntj 1st 15 min	1st 15 minutes
97130	GN	Ther ivntj ea addl 15 min	Each additional 15 minutes
97533	GN	Sensory integration	Timed 15 min units
97550		Caregiver training 1st 30 min	Code status: By Report (BR)
97551		Caregiver training ea addl 15	Code status: By Report (BR)
97552		Group caregiver training	Code status: By Report (BR)
S9152	GN	Speech therapy, re-eval	

Audiologists

CPT® Code	Modifier	Short Description	Comments
69210	AF	Remove impacted ear wax	
92521	AF	Evaluation of speech fluency	
92522	AF	Evaluate speech production	
92523	AF	Speech sound lang comprehen	
92524	AF	Behavral qualit analys voice	
92537	AF	Caloric vstblr test w/rec	

CPT® Code	Modifier	Short Description	Comments
92541	AF	Spontaneous nystagmus test	
92542	AF	Positional nystagmus test	
92544	AF	Optokinetic nystagmus test	
92545	AF	Oscillating tracking test	
92546	AF	Sinusoidal rotational test	
92547	AF	Supplemental electrical test	
92550	AF	Tympanometry & reflex thresh	
92551	AF	Pure tone hearing test, air	
92552	AF	Pure tone audiometry, air	
92553	AF	Audiometry, air & bone	
92555	AF	Speech threshold audiometry	
92556	AF	Speech audiometry, complete	
92557	AF	Comprehensive hearing test	
92558	AF	Evoked otoacoustic emissions screening- audiologists	
92567	AF	Tympanometry	
92568	AF	Acoustic reflex testing	
92570	AF	Acoustic immittance testing	
92579	AF	Visual audiometry (vra)	
92582	AF	Conditioning play audiometry	
92584	AF	Electrocochleography	
92587	AF	Evoked auditory test	
92588	AF	Evoked auditory test	
92601	AF	Cochlear implt f/up exam < 7	

CPT® Code	Modifier	Short Description	Comments
92602	AF	Reprogram cochlear implt < 7	
92603	AF	Cochlear implt f/up exam 7 >	
92604	AF	Reprogram cochlear implt 7 >	
92611	AF	Motion fluoroscopy/swallow	
92620	AF	Auditory function, 60 min	
92621	AF	Auditory function, + 15 min	
92625	AF	Tinnitus assessment	
92626	AF	Oral function therapy	
92627	AF	Oral speech device eval	
92630	AF	Aud rehab pre-ling hear loss	
92633	AF	Aud rehab postling hear loss	
92650	AF	Aep scr auditory potential	
92651	AF	Aep hearing status deter i&r	
92652	AF	Aep thrshld est mlt freq i&r	
92653	AF	Aep neurodiagnostic i&r	
97533	AF	Sensory integration	One 15-minute increment equals one visit

Occupational Therapy

CPT® Code	Modifier	Short Description	Comments
64550		Apply neurostimulator	Not covered
92526	GO	Oral function therapy	
95851	GO	Range of motion measurements	Excluding hands

CPT® Code	Modifier	Short Description	Comments
95852	GO	Range of motion measurements	Including hands
96112	GO	Devel tst phys/ghp 1st hr	Covered under the physician fee schedule for qualified providers
96113	GO	Devel tst phys/qhp ea addl	Covered under the physician fee schedule for qualified providers
96125	GO	Cognitive test by hc pro	
97165	GO	OT eval low complex 30 min	
97166	GO	OT eval mod comple 45 min	
97167	GO	OT eval high complex 60 min	
97168	GO	OT re-eval est plan care	
97010	GO	Hot or cold packs therapy	Included in Primary services. Bundled
97014	GO	Electric stimulation therapy	
97018	GO	Paraffin bath therapy	
97032	GO	Electrical stimulation	Timed 15 min units
97034	GO	Contrast bath therapy	Timed 15 min units
97110	GO	Therapeutic exercises	Timed 15 min units
97112	GO	Neuromuscular reeducation	Timed 15 min units
97113	GO	Aquatic therapy/exercises	Timed 15 min units
97124	GO	Massage therapy	Timed 15 min units
97140	GO	Manual therapy	Timed 15 min units
97150	GO	Group therapeutic procedures	
97530	GO	Therapeutic activities	Timed 15 min units
97533	GO	Sensory integration	Timed 15 min units

CPT® Code	Modifier	Short Description	Comments
97535	GO	Self-care management training	Timed 15 min units
97542	GO	Wheelchair management training	Assessment is limited to four 15-min units per assessment. Indicate on claim wheelchair assessment
97550		Caregiver training 1st 30 min	Code status: By Report (BR)
97551		Caregiver training ea addl 15	Code status: By Report (BR)
97552		Group caregiver training	Code status: By Report (BR)
97597	GO	Active wound care/20 cm or <	Do not use in combination with 11040-11044. Limit one per client per day
97598	GO	Active wound care > 20 cm	Do not use in combination with 11040-11044
97602	GO	Wound(s) care non-selective	Do not use in combination with 11040-11044
97605	GO	Neg press wound tx, <50 cm	Included in Primary services. Bundled
97606	GO	Neg press wound tx, >50 cm	Included in Primary services. Bundled
97750	GO	Physical performance test	Do not use to bill for an evaluation
97755	GO	Assistive technology assess	Timed 15 min units
97760	GO	Orthotic management and training	Can be billed alone or with other PT/OT procedure codes
97761	GO	Prosthetic training	Timed 15 min units

CPT® Code	Modifier	Short Description	Comments
97763	GO	Orthc/prostc mgmt sbsq enc	
97799	GO & RT or LT	Physical medicine procedure	Use this code for custom hand splints. Use modifier to indicate right (RT) or left (LT) hand. Documentation must be attached to claim.

Payment

What must an NDC do to be reimbursed by the Health Care Authority?

To be reimbursed for the services listed in the coverage section, an NDC must:

- Contract with the Department of Health (DOH) as a neurodevelopmental center.
- Provide documentation of its DOH contract to the Health Care Authority.
- Have an approved core-provider agreement with the Health Care Authority.

To be reimbursed for the services listed in the coverage section, each service must be:

- Covered by the client's benefit package.
- Medically necessary, as defined in WAC 182-500-0070.
- Within the scope of the eligible client's medical care program.
- Ordered by a physician, physician assistant (PA), or an advanced registered nurse practitioner (ARNP).
- Begun within 30 days of the date ordered.
- Provided by an approved health professional.
- Billed according to this guide.
- Provided as part of an outpatient treatment program in a neurodevelopmental center, as described in WAC 182-545-900.

What services does the Health Care Authority not pay for?

The Health Care Authority does not pay for:

- Duplicate services for the same client when two or more providers are performing the same or similar intervention on the same date.
- Services included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services (see WAC 182-545-900).

Washington State Health Care Authority

Billing

All claims must be submitted electronically to the Health Care Authority, except under limited circumstances.
For more information about this policy change, see **Paperless Billing at HCA**.
For providers approved to bill paper claims, see the Health Care Authority's **Paper Claim Billing Resource**.

Are servicing provider national provider identifiers (NPIs) required on all claims?

Yes. Neurodevelopmental centers (NDCs) must use the servicing provider's national provider identifier (NPI) on all claims in order to be paid. If the servicing provider's NPI is not listed on the claim, the claim may be denied. Providers must follow the billing requirements listed in the Health Care Authority's **ProviderOne Billing and Resource Guide**.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the Health Care Authority's **Billers and Providers webpage**, under **Webinars**.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the **HIPAA Electronic Data Interchange** (EDI) webpage.

Are modifiers required for billing?

Yes. Neurodevelopmental centers must use the appropriate modifier when billing the Health Care Authority:

Modality	Modifiers
Physical Therapy	GP
Physical Therapy Assistant	CQ
Occupational Therapy	GO
Occupational Therapy Assistant	CO
Speech Therapy	GN
Audiology and Specialty Physician	AF

The Centers for Medicare & Medicaid Services (CMS) has established two modifiers, CQ and CO, for services furnished in whole or in part by physical therapy assistants (PTAs) and occupational therapy assistants (OTAs). The modifiers are defined as follows:

- **CQ modifier:** Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant
- **CO modifier:** Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant

Effective for claims with dates of service on and after January 1, 2020, the CQ and CO modifiers are required to be used, when applicable, for services furnished in whole or in part by PTAs and OTAs on the claim line of the service alongside the respective GP or GO therapy modifier, to identify those PTA and OTA services furnished under a PT or OT plan of care. Claims not so paired will be rejected/returned as unprocessed.

What are the general billing requirements?

Providers must follow the Health Care Authority's ProviderOne Billing and Resource Guide. These billing requirements include the following:

- What time limits exist for submitting and resubmitting claims and adjustments
- When providers may bill a client
- How to bill for services provided to primary care case management (PCCM) clients
- How to bill for clients eligible for both Medicare and Medicaid
- How to handle third-party liability claims
- What standards to use for record keeping